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THE RELATIONSHIP BETWEEN SOCIAL WORKERS' ALCOHOL OR DRUG USE AND SUBJECTIVE WELL-BEING

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THE RELATIONSHIP BETWEEN SOCIAL WORKERS' ALCOHOL
OR DRUG USE AND SUBJECTIVE WELL-BEING

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Gustavo Torres
Katherine Clair Newell Tristán
June 2014

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ABSTRACT

The relationship between alcohol or drug use and subjective well-being among master of social work students and practitioners was examined. Subjective well-being measures included core, life satisfaction, affect, eudaimonia and domain evaluation. Frequency of alcohol, tobacco, cannabinoids and psychotropic drug use was collected. There were modest to moderate negative correlations between alcohol and life satisfaction and eudaimonia. There were moderate negative correlations between psychotropic medication and life satisfaction, eudaimonia and domain. There was a modest negative correlation between tobacco and life satisfaction and a strong negative correlation between tobacco and eudaimonia. There were no significant correlations with cannabinoids in any subjective well-being measure. Together, these findings suggest that alcohol or drug use has little effect on subjective well-being.

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CHAPTER ONE

INTRODUCTION

This chapter begins with a description of the historical background of substance use. Next it describes the social work response to substance use. The purpose of the study, examining the alcohol and drug use patterns of social workers and their perceptions of their own well-being, is then discussed. This is followed by a discussion of the significance of the study for the social work profession.

Historical Background

For centuries various intoxicating substances have been used for religious purposes, to enhance creativity or for recreational purposes. For thousands of years the Chinese have been using cannabis medicinally, and the South Americans have been chewing coca leaves for energy. Native Americans continue to use peyote for various ceremonies. Historically speaking, condemnation of substance use is a recent social construct. Until the late 1800s, alcohol use and drunkenness were acceptable in the United States, and cocaine and opiates were widely used as well, largely by the upper classes (Nelson, 2012; National Association of Social Workers, 2008). In fact, most addicts prior to the 1960s were those from the upper classes: doctors, dentists and pharmacists, as they were the ones with easy access to drugs (Nelson, 2012). It was not until almost 1900 that first alcohol use and,

later, other drug use began to be seen as a social problem. As a result, several acts were passed that criminalized various intoxicants, and social viewpoints changed to the extent that drug and alcohol use and abuse were now seen as a personal shortcoming.

In the 1930s Alcoholics Anonymous (AA) was formed. Between this time and the 1970s, alcohol and drug treatment programs became more formalized and moved from a volunteer effort to privatization (Siebert, 2001). In 1970, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) were instituted (National Association of Social Work, 2008). The purpose of these institutions was, and is, to conduct research on alcohol and drug use and addiction. Currently, NIAAA funds more alcohol related research than any other institution in the world (NIDA, n.d.; NIAAA, n.d.). Between 1967 and 1976, the United States experienced a heroin epidemic that claimed about 1,000 lives per year. This led to the creation of the Controlled Substance Act of 1970, also known as the “War on Drugs” (Dufton, 2012; Nelson, 2012). Currently, the major federal institute dealing with this issue is the Substance Abuse and Mental Health Services Administration (SAMHSA) (Marsiglia, F. F., & Becerra, 2008). SAMHSA uses a three pronged approach toward substance use: local/international law enforcement, drug prevention and research on prevention, and drug treatment and research on treatment (National Association of Social Work, 2008). The ebb and flow of societal views

regarding substance use continues. For example, perceptions regarding cannabis, once vilified by movies such as *Reefer Madness* (Gasnier, 1938), have shifted. Seventeen states either allow medical marijuana, have decriminalized marijuana use, or have legalized it for recreational use. Several other states have legislation pending to follow one of these paths. These changes indicate that Americans no longer support the criminalization of cannabis and are willing to legalize or decriminalize it.

Statistics Regarding Substance Use

While other professions have assiduously conducted studies to examine the levels of substance use among their particular population, social workers have been slow to do the same thing. Research regarding the substance use among the social worker population has been sketchy and lacking in evidence based methodology (Negreen, 1995). Social workers seem reluctant to conduct research on themselves. In fact, “(a)ll the evidence seems to point to a profession that is in denial about potential distress and impairment among its membership” (Siebert, 2001).

If the substance use patterns of the general population are true for social workers, then alcohol, tobacco, cannabinoids and psychotherapeutic drugs are the four most common categories of substances used. The statistics from the NIAAA (National Institute on Alcohol Abuse and Alcoholism, n.d.) indicate that among persons 18 or older, 59.6% of women and 71.8% of men had consumed at least one alcoholic beverage in the past year and

considered themselves “drinkers.” (National Institute on Alcohol Abuse and Alcoholism, n.d.) The National Institute on Drug Abuse (NIDA) maintains statistics for the use of various substances and states that 82.2% of those 12 and older have used alcohol in their lifetimes, 62.8% have used tobacco, 41.8% have used cannabinoids, and 19.9% have used psychotherapeutic drugs. Generally speaking, these numbers are a bit higher for those aged 18 or older and lower for those under the age of 18 (National Institute on Drug Abuse, n.d.).

Social Work Response

Until alcohol and drug use became a social issue, social workers were not involved with clients specifically due to their substance use until the 1970s. Some, though, spoke out early, including Mary Richmond who wrote Social Diagnosis. In this book she argued that alcoholism is a disease, not a personal shortcoming (Richmond, 1955). Regarding substance use and abuse by social workers, the NASW was silent until 1979 when the association first published a statement regarding social workers with alcohol problems (National Association of Social Workers, 2003). It was not until 1987 that NASW specifically addressed professional impairment through policy statements (Pooler, 2005). In 1996 NASW began to address impairment in the NASW Code of Ethics. Section 4.05 of the code states:

- (a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental

health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others (NASW, 2008).

The code goes on in section 2.09 to clarify the responsibilities of social workers who are aware of the impairment of their co-workers.

(a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers,

agencies, NASW, licensing and regulatory bodies, and other professional organizations (NASW, 2008).

Though social worker impairment has now been addressed by NASW at a national policy level, at a local program level it is barely addressed. In 1980, NASW started Social Workers Helping Social Workers (SWHSW) which later became the Colleague Assistance Program (CAP). These programs are intended for individual NASW chapters to assist their members with substance use problems. Though the NASW supports the use of these programs by local NASW chapters, there is no requirement that the local level groups offer them. As a result, few NASW chapters have CAPs; they are rare, and they are grossly underutilized. Additionally, few chapters have CAPs in development for the future (Negreen, 1995; Siebert, 2001).

Purpose of the Study

Little research has been conducted regarding substance use by social workers. Perhaps as a result of the censorious view society takes of substance use, social workers are unlikely to seek help with their substance abuse issues. Additional reasons for not seeking out assistance include feeling counseling is ineffective, being worried that the provider was someone they knew, and worries about confidentiality or the effect that seeking treatment might have on the professional life (Siebert, 2005). As a result, relatively little is known, even generally, about the levels of substance use among social workers, their substance use habits, or their level of impairment; This lack of

data has been pointed out with a call for empirical studies (Pooler, 2005). Depending on whether social workers are users or abusers, they may find that their use of substances allows them to relax or decreases their stress levels, and they do not perceive any decline in their well-being. Others develop problematic substance use and their level of impairment may lead to harm of their clients through inadequate client care, a strain on resources both within the social worker's agency as well as to the clients they serve, and a negative opinion of the organization for which they work (Pooler, 2005). Though a lot of attention has been given to impaired professionals, a survey of the 781 ethics code violations by social workers between 1986 and 1997 showed that only eight were a result of impairment due to substance use (Siebert, 2001).

Significance of the Study

It seems important to examine the use and abuse of substances by social workers, given that social workers are the largest group of mental health practitioners in the United States (National Association of Social Workers, 2008). As with other professional groups engaged in high stress jobs, social workers should examine their own levels of use.

The objective of this paper is not to put forth a particular hypothesis, but rather to gather data in two areas. The first area is to determine frequency of use of alcohol, tobacco, cannabinoids, and psychotropic drug use among Masters in Social Work Interns (MSWI) at California State University, San Bernardino as well as Masters in Social Work (MSW) practitioners in the

southern California region. The second area is to collect information regarding the participants' levels of high or low subjective well-being.

This study can further the understanding of the relationship between these two areas of concentration and can contribute to the field in a positive way. For example, the study will gather data on MSW practitioners and MSWI which can potentially be used to address any problems or issues present within the social work field and can contribute to the field by increasing knowledge regarding substance use. Additionally, the topic of this paper may be of interest to different other groups. If the results of the study indicate that substance abuse or dependence is of significant concern, agencies (for MSWs) and the school of social work at CSUSB (for MSWIs) can attempt to address the findings.

The findings of this paper can also assist MSWI by helping them identify and anticipate common risk factors that appear to be inherent with a career in social services. Doing so can improve overall health and functioning by implementing preventative measures or changing policy to support the current and future MSWs.

The research question guiding the study is: Through the application of a subjective well-being framework, how is AOD use among MSW and MSWI correlated with subjective well-being?

CHAPTER TWO: LITERATURE REVIEW

This chapter presents the framework used to describe subjective well-being. First, the instrument used to evaluate subjective well-being is discussed. The instrument was composed of different components (life evaluation/satisfaction, affect, and eudaimonia) that influence how subjective well-being is defined by an individual. The researchers used the three aforementioned components, each represented by a module, along with two other modules that contribute to the measurement of subjective well-being, core evaluation and domain evaluation. Second, theories of subjective well-being are presented to provide a generalized definition of subjective well-being. Finally, the components that make up the instrument are elaborated upon to provide information about how each component is useful when measuring subjective well-being. Along with the theories and components, AOD use and its relationship with subjective well-being is briefly examined.

The survey for this study used question modules from a report by the Organisation for Economic Co-operation and Development (OECD) under its Better Life Initiative titled “Guidelines on Measuring Subjective Well-being”. The five modules include components that the survey gathered data for. The core evaluation module intends to capture the respondent’s evaluative judgment of how their life is going, if things in their life are worthwhile, and to

characterize the affective state of the respondent on the previous day (OECD, 2013, p. 253). It includes a question that evaluates life satisfaction, a question that evaluates eudaimonia and three questions that evaluate affect. It appears to best represent the components that make up subjective well-being and could possibly be used independently to measure subjective well-being. However, the researchers chose to include the other four more modules to better evaluate subjective well-being.

The first component, life evaluation, has statements that seek to validate relative happiness and life satisfaction, rating items such as, “The conditions of my life are excellent,” or “I am satisfied with my life”. The second component is affect; it seeks to measure feelings such as daily enjoyment, worry, or depression. The third component is made up of eudaimonic questions and asks the respondent to rate items such as “I’m always optimistic about my future,” or “Most days I get a sense of accomplishment from what I do.” The domain evaluation is the fifth module, and includes satisfaction ratings regarding personal relationships, safety, health and employment. The questions in these various domains help to determine generally how well or poorly a person perceives their life to be going. The measures included in this survey are those that have been found to have the greatest validity and relevance for judging subjective well-being (OECD, 2013).

Theories of Subjective Well-Being

Different models have been developed that attempt to define subjective well-being. Borrello (2005) described two overarching theories: the top-down perspective and the bottom-up theory. The top-down perspective states that personality traits influence the way a person perceives events. In bottom-down theory the belief is that there are universal basic human needs and that happiness results from their fulfillment. Subjective well-being as defined in this paper borrows from both of these theories. Borrello goes on to state that no single theoretical approach can clearly describe the underlying processes that are responsible for subjective well-being (2005, p. 13). By referencing both theoretical approaches, the interaction of different factors/processes allows for personality traits (top-down perspective) to influence how an individual experiences an event and how it will affect them as they pursue positive experiences or happiness (bottom-down theory). Using both theories allowed the researchers to better understand how each module contributes to subjective well-being. What follow are other theories of subjective well-being that are more specific in describing subjective well-being.

Hall (2008) presented the narrative capacity theory of well-being. According to this theory, well-being is whatever [an individual] designates it to be. Hall states that a theory of well-being (using the narrative approach) has two aspects: the ordinary, societal usage of the term and the way that an individual determines the content of their own well-being. For this study,

well-being was defined as how someone perceives their own life through the interaction of internal and external factors. Thus, one person's idea of high well-being may not be the same for someone else because well-being is biased and constantly shifting.

Shier and Graham (2011) stated that subjective well-being encompasses multiple aspects of a person's life and is influenced by their environment, perspectives, daily activities and practices. Shier and Graham recognized the importance of macro, mezzo, and micro factors and their interactions. These interactions cause shifts in an individual's perception of what is well-being. What someone perceives as high well-being at an early age may start being perceived as moderate or even low well-being later in adulthood. Pooler (2005) found that social workers do experience impairment but that positive levels of self-esteem, coping, social support, and organizational wellness helped to protect them against problems with substance use, depression, and relationship problems. The positive correlation between protective factors such as coping and reduced impairment suggests that substances can be used recreationally as well as medically or for self-medicating purposes and not negatively contribute to subjective well-being.

Wilson (2004) found that the majority of female graduate students from an alcohol and drug survey did not experience any consequences from their substance use. It can be argued that due to the level of education they have

achieved, female *and* male graduate students, and by extension MSW's, are capable of using substances recreationally and perceiving that they are doing well in accordance to their own standards of well-being. Wilson's findings further support the idea that AOD use does not guarantee impairment or that AOD use contributes significantly to subjective well-being. Next, the components that make up subjective well-being are discussed in order to better understand why they were used to measure subjective well-being.

Components of Subjective Well-Being

Life Satisfaction

Life satisfaction is considered to strengthen evaluation of subjective well-being by allowing for self-reflection of one's own life, the totality of their experiences. Affect evaluates immediate here-and-now feelings and by measuring for life satisfaction the evaluation of subjective well-being is more complete due to its long-term evaluation. Also, life satisfaction surveys are thought to complement existing indicators by reflecting the influences of diverse facets of quality of life and allowing respondents to freely weight different aspects (Deiner et al., 2013). Therefore, life satisfaction allows for an individual's internal thought process to weigh different processes to help determine their subjective well-being.

Life satisfaction is also seen as a good predictor of future outcomes. Deiner, Inglehart, and Tay (2013) reference a study which found that life satisfaction predicted suicidal ideation twenty years later while controlling for

other risk factors such as age, gender, and substance use. Positive life satisfaction evaluations positively correlated with reduced suicidal ideations and substance use was not found to correlate strongly with life satisfaction. Again, this reaffirms the assumption that AOD use does not strongly influence subjective well-being levels. Life satisfaction also relates to the cognitive evaluation, judgment, or declaration that individuals make about the quality of their lives, including expectations, comparison to others, and other cultural aspects (Hamama et al., 2013). This is a process that influences an individual's identity and how they frame their lives in the long-run.

Affect

McKennell and Andrews (1980) described affect as an individual's immediate feeling state which is not anchored. Affect shifts depending on the circumstances an individual finds themselves in. In regards to positive and negative affect, Deiner (2000) described positive affect as experiencing many pleasant emotions and moods and negative affect as experiencing few unpleasant emotions and moods. An interpretation of this definition is that in order to have a high level of positive affect, levels of negative affect must be low. Since affect is not a fixed feeling it can shift periodically. For example, someone who recently graduated from college may feel more positive than negative affect while someone who lost their job might experience more negative than positive affect.

Zajonc (1980) suggested that affective reactions can occur without extensive perceptual and cognitive encoding and can be made sooner and with greater confidence than cognitive judgments. These reactions are more time bound and tend to occur right after an event. Despite the quickness in which they occur, people tend to feel confident in the affect that the event established. For example, someone may feel positive affect after quitting a job that they disliked. After the initial “high” wears off, they may begin to regret their decision. However, despite the negative affect, they are confident in their decision. Hamama et al (2013) referenced two studies which emphasized that positive affect plays an important role in coping with stressful situations. Again, due to a quick but confident reaction, positive affect can help deal with a stressful situation in ways that other, more complicated processes, cannot. The researchers believe that affect’s here-and-now process can complement more long-term processes like life evaluation which is measured by using another module.

Hamama, Ronen, Shachar, and Rosenbaum (2013) agree with the idea that accentuation of positive emotion coincide with the general human wish to lead more productive and fulfilling lives and to identify and nurture talents. Hamama and his colleagues go on to state that the capacity to experience more positive than negative emotion was attributable to someone’s ability to flourish. As graduate students and as practitioners holding a Masters of Social Work, both target groups have proven that they are capable of attaining high

academic achievement and continuously looking to nurture their own and others' talents.

Moneta, Vulpe, and Rogaten (2012) hypothesize that positive affect gives way to more positive affect which can prevent negative affect from occurring. As a person experiences more and more positive affect their capacity to experience negative affect is diminished, which can lead to less negative coping. If someone is effectively stopping negative affect from occurring then it can be argued that their evaluation of subjective well-being is more positive. Borrello (2005) also believes that positive emotions and optimism can be beneficial to subjective well-being. These two ideas suggest that AOD use can be positively correlated with subjective well-being. Engaging in AOD use while experiencing positive emotions and mood can lead to AOD use that is recreational and compliments positive well-being as opposed to impeding or hindering it.

Eudaimonia

The Organisation for Economic Co-operation and Development (2013) described eudaimonia as a sense of meaning and purpose in life or good psychological functioning. Further, the questions for eudaimonia [in the survey] are relatively diverse and cover a range of different mental attributes and functionings that are thought to constitute mental "flourishing" (OECD, 2013, p 259). Tan Bhala (2009) defined eudaimonia as living according to virtues that are guided by reason in a complete life. Waterman et al. (2008) described it as

the subjective experiences associated with doing what is worth doing and having what is worth having. Based on these definitions, eudaimonia appears to require that an individual engage in self-reflection and determine how their life is going based on what they see as important and what they think gives meaning to their lives. Waterman et al (2008) suggested that identity development will proceed most successfully when individuals are able to identify their best potentials and engage in activities that move toward realizing those potentials. If an individual is able to successfully realize their potentials then it can be said that they are flourishing or experiencing positive levels of eudaimonia. It is not clear whether eudaimonic well-being captures a single underlying construct like life evaluation, or is rather an intrinsically multi-dimensional concept like affect (OECD, 2013). Therefore, the OECD considered this module to be experimental.

In efforts to make this module more concrete, the researchers looked at the relationship between eudaimonia and happiness. Tan Bhala (2009) and Yan (2011) both recognized that happiness is often grouped with, or considered to be the same as, eudaimonia. Happiness can be defined as the satisfaction of desires and goals. Similar to eudaimonia, the fulfillment of these desires and goals can be compared to a person fulfilling their best potential. Studies focusing on the consequences of subjective well-being suggest that happiness appears to have almost exclusively positive consequences on adult's cognition, activity level, social standing and health outcomes (Borrello,

2005). Borrello goes on to argue that happy people tend to develop and maintain healthy relationships, are highly social, and spend less time alone, among other benefits. The findings presented by Borrello indicate that AOD use may not correlate negatively with subjective well-being if the respondents report positive levels of eudaimonia or happiness.

Summary

This chapter discussed theories of subjective well-being, the components that were used to further define subjective well-being and the possible relationship that subjective well-being will have with AOD use based on findings in the literature. The way that subjective well-being was described and the use of modules that measure short-term and long-term subjective well-being such as affect and life satisfaction, shows that subjective well-being encompasses multiple aspects of a person's life and is processed in different ways by each person. The manner in which the information was presented suggests that low, moderate, or high levels of AOD use may not strongly influence how a person evaluates their subjective well-being. Therefore, the research question for this study is: What is the relationship between social worker's AOD use their subjective well-being?

CHAPTER THREE

METHODS

Introduction

This chapter will first give relevant definitions and describe the study design for this research project. A discussion of the sampling, data collection and instruments, and procedures follows. The protection of the confidentiality of the participants is covered, followed by the description of the data analysis and a short chapter summary.

Definitions

For the purposes of this study subjective well-being, impairment, substance abuse, and recreational drug use will be defined as follows. Subjective well-being is defined as the way someone perceives their own life through the interaction of internal and external factors. Impairment is “the state of being diminished, weakened, or damaged, especially mentally or physically (Impaired, 2009).” Substance abuse can be defined as “The continued use of alcohol and/or other drugs in spite of adverse consequences in one or more areas of an individual’s life (Fisher & Harrison, 2013).” Substance use that is for non-medical, personal enjoyment is the definition of recreational drug use.

Study Design

The purpose of this study was to gather information regarding the relationship between social workers’ alcohol or drug use and subjective

well-being. A survey research design was used for this study. The survey collected data regarding the person's SWB as well as their AOD use. The data was collected using a quantitative survey distributed to the participants via an online survey service, SurveyGizmo. This allowed the participants to complete the survey online, at their convenience.

There are advantages and disadvantages to using an online survey as opposed to a paper and pencil survey. Online surveys eliminate the costs of paper, postage and multiple mailings involved with paper surveys. Additionally, there is an increased sense of anonymity with online surveys. A disadvantage of online surveys is the necessity of access to a computer. Additionally, it lacks the immediacy of a pen and paper survey (Van Selm & Jankowski, 2006). This is less of a disadvantage with this particular population as they are professionals and graduate students who likely have easy access to the computer and the basic knowledge needed to complete the survey.

Research indicates that the response rates are comparable for surveys that were mailed to participants and those that were administered over the internet. However, responses are received more quickly with internet surveys (Schaefer & Dillman, 1998). Another advantage to internet surveys is that they are less likely to have un-codeable responses, as is often the case with handwritten surveys (Pettit, 2002).

Sampling

The sample consisted of current California State University, San Bernardino (CSUSB) Masters of Social Work (MSW) students and current MSW. The sample should accurately reflect the social work population as it encompassed a diverse set of social workers from different backgrounds and career paths.

The MSW students received flyers in their student mailboxes inviting them to participate in the on-line survey (Attachment 1). Requests for participation from MSW practitioners were sent to two on-line social work groups: the NASW-CA Social Justice Social Action Council and CalSWEC Grad Jobs. It was hoped that the dissemination of the request for participation through established email lists would help to gain a larger sample size. Chain-referral (snowball) sampling was utilized as well.

Data Collection and Instruments

Measuring Subjective Well-Being

The first set of data, measures of SWB, is derived from five modules designed to measure subjective well-being. The instrument used for this is taken from the Organisation for Economic Co-operation and Development (OECD). The OECD was formed in 1961 when the United States and Canada joined the Organisation for European Economic Cooperation (OEEC), established in 1948 to run the Marshall Plan after World War II. A recent goal of the OECD is to measure SWB within and across country populations to

provide information to various governments about their citizens' perceptions of well-being specific to their own country, so as to allow for policy development as well as to coordinate international efforts. Their instrument for measuring SWB has been extensively tested for reliability and validity over the past twenty years.

The measures for SWB include employment status, health status, work/life balance, education and skills, social connections, civic engagement and governance, environmental quality, personal security, and psychological measures (OECD, 2013). These areas of interest have been condensed into five measures: core evaluation, life evaluation, affect, eudaimonic well-being, and domain evaluation. Each of these five measures is examined through one of five modules. The first of these five modules is an abbreviated survey which includes the three components that make up subjective well-being (life satisfaction, affect, eudaimonia), to be used as an overview, with the four additional modules going into more detail about each of the three components.

Reliability occurs when the measure produces the same results when carried out in the same circumstances. Reliability for this study is measured in two ways, through internal consistency reliability and through test-retest reliability. In general, 0.7 is considered an acceptable level of internal consistency reliability. Multi-item tests for SWB have reliably scored in the 0.8 to 0.96 range (OECD, 2013). Test-retest scores are lower, in the 0.5 to 0.7

range as they are measures that are “measures of momentary affect” (OECD, p. 48).

Validity is more difficult to test for subjective measures. In the literature about validity, there are three measures that show that a test is valid: face validity, convergent validity, and construct validity. The evidence is strong that the measure is valid in all three areas.

The second set of data to be collected was a report of personal use of the four most common categories of AOD substances: alcohol, cannabinoids, tobacco products, and psychotropic drugs such as anti-depressants or anti-anxiety drugs. A simple self-report instrument of AOD use was created by the researchers (Attachment 2). This instrument asked, for each of the four substances, alcohol, tobacco, cannabinoids and psychotropic drugs, whether the respondent had: never used the substance, used to use it, used it one to three times per year, several times per year, about once a month, one to three times per month, nearly once a week, once a week, or daily.

Demographic data was collected as well. This included age, gender, race, education level, marital status and practice setting.

Procedures

Data were collected on-line using SurveyGizmo. The Statistical Package for the Social Sciences (SPSS) was used to analyze the data. It was assumed that target population has access to computers with internet access. Because most (if not all) MSW students and practitioners have internet access

it was expected that this method of data collection will lead to a good response rate and more accurate responses by the participants because of the anonymity. The survey was expected to take, at most, 15 minutes to complete.

The timetable for the study was as follows: first, clearance to conduct study was obtained from the Director of the Social Work program at CSUSB and through the Internal Review Board (IRB). Next, the researchers distributed flyers and emailed requests for participation to students, social workers and organizations in their networks. Collection of data was made through the online survey service SurveyGizmo. Data was then analyzed and interpreted.

Protection of Human Subjects

The individuals studied in this project had their confidentiality protected by the researchers who kept all information confidential and the participant's anonymity was protected by the nature of the online survey. The taking of the survey implied consent, though an informed consent page was included at the beginning of the survey and a debriefing statement was included as the final screen.

Data Analysis

Quantitative analysis was employed for the data using SPSS. The relationships between social workers' alcohol or drug use and subjective well-being were examined. Each type of substance included, alcohol, tobacco, cannabis, and prescription medication were examined for their positive or

negative correlative relationship with subjective well-being. For example, it may result that those engaging in cannabis use have a higher rate of subjective well-being than those using psychotropic medication.

Measurement

The level of measurement of this SWB portion of this study is ordinal. Responses were measured using a Likert scale (i.e. point scale). Questions regarding AOD choice and frequency of consumption were ratio measurements. Descriptive statistics were used to describe and summarize the variables of interest. Life satisfaction, affect and eudaimonia are the components that make up the concept of subjective well-being for this study. Univariate analyses were conducted in order to examine the relationship between each of the four substances and the areas related to subjective well-being.

CHAPTER FOUR

RESULTS

Demographics

Table 1 presents the demographic information for the MSW and MSWI participants. The majority of the group was between the ages of 25 and 34, with the next largest group between 35 and 54 years of age. Most of the respondents (84.8%) were female. Caucasians (47%) were the largest group in this population, with Hispanics the next largest group (33.3%). Most of the group was either married or in a committed relationship (53%), followed by those never married (33.3%) and then those widowed, divorced or separated. Of the 66 respondents, 44 were MSW students and 22 were MSW practitioners. The majority of the respondents work in mental health (60.6%), with the next largest group being those who work in children and family services (15.2%).

Table 1. Demographic Variables

Demographic	Frequency	Percent
Age		
18-24	10	15.2
25-34	31	47.0
35-54	23	34.8
55+	2	3.0
Total	66	100.0

Demographic	Frequency	Percent
Gender		
Male	9	13.6
Female	56	84.8
No response	1	1.5
Total	66	99.9*
Ethnicity		
Asian/Pacific Islander	6	9.1
Black/African American	1	1.5
Caucasian	31	47.0
Hispanic	22	33.3
Other/Multi-racial	5	7.6
Declined to respond	1	1.5
Total	66	100.0
Marital Status		
Married	19	28.8
Widowed	1	1.5
Divorced	4	6.1
Separated	2	3.0
Never married	22	33.3
Committed relationship	16	24.2
No response	2	3.0
Total	66	99.9*
Practitioner level		
MSW student	44	66.7
MSW practitioner	16	24.2
LCSW	6	9.1
Total	66	100.0

Demographic	Frequency	Percent
Practice setting		
Mental health	40	60.6
Children/family service	10	15.2
Addiction services	2	3.0
Older adults	2	3.0
Other	12	18.2
Total	66	100.0
*. 99.9% due to rounding		

Alcohol or Drug Use Frequency

The frequency with which the respondents used AOD is shown in Table 2. Alcohol was the substance most frequently used by the participants with 77.3% responding that they use alcohol. Only 22.7% said they had never used, or no longer used, alcohol. The rest of the numbers were distributed between the yearly, monthly, weekly and daily choices. Most of the respondents, (60.6%) had never used tobacco and only 19.7% currently use tobacco. Psychotropic drugs were the least frequently used drug. Most had never used them (66.7%), or used to use them (10.6%). A slight majority of the group had never used cannabinoids with the next largest group being those who used to.

Table 2. Frequencies of Alcohol Use

Use	Alcohol Frequency	Alcohol Percentage	Tobacco Frequency	Tobacco Percentage	Psychotropic Frequency	Psychotropic Percentage	Cannabinoid Frequency	Cannabinoid Percentage
Never	6	9.1	40	60.6	44	66.7	26	39.4
Used to	9	13.6	12	18.2	7	10.6	25	37.9
1-3x/ year	11	16.7	6	9.1	1	1.5	5	7.6
Several x/year	8	12.1	0	0	0	0	2	3.0
1x/mont h	9	13.6	1	1.5	3	4.5	0	0
1-3x/ month	6	9.1	0	0	1	1.5	3	4.5
Nearly weekly	7	10.6	0	0	0	0	0	0
Every week	7	10.6	1	1.5	1	1.5	0	0
Every day	2	3.0	0	0	7	10.6	0	0
Several x/day	0	0	5	7.6	1	1.5	4	6.1
No response	1	1.5	1	1.5	1	1.5	1	1.5
Total	66	99.9	66	100.0	66	99.9	66	100.0

Table 3 presents the findings from the core evaluation questions on the correlative relationship between respondent’s evaluative judgment of how their life is going overall and their alcohol and other drug (AOD) use. As described in Chapter 2, the core measures are a general overview of a person’s subjective well-being. The four additional models provide more detailed information. Pearson r correlations were used to assess this relationship.

There were no significant findings between any of the four substances and core evaluation. This might mean that AOD use does not significantly affect how respondents felt their lives were going overall.

Table 3. Correlations between Alcohol and Other Drug (AOD) Use and Core Evaluation

(n = 66)	Alcohol	Tobacco	Cannabis	Medications
Satisfaction w/ life as whole	-.158	-.123	-.168	-.222
Worthwhileness of things being done	-.037	-.107	-.049	-.128
Felt happy yesterday	-.122	-.112	-.063	-.095
Felt worried yesterday	-.069	.141	-.071	.051
Felt depressed yesterday	-.127	-.029	.045	-.002
Overall core	-.012	-.191	-.085	-.183

*. No significant correlations were found

Table 4 presents the findings from the life evaluation module on the correlative relationship between respondent's life evaluation and their AOD use. Pearson r correlations were used to assess this relationship. A significant relationship was found between alcohol use and life evaluation. Question B9 "If I could live my life over, I would change almost nothing" was found to have a moderate negative correlation ($r = -.302$; $p = .015$). This means that the

more respondents' consume alcohol the more likely they were to change aspects of their lives if they could live their life over.

There were multiple significant findings between tobacco use and life evaluation. Question B3 "Overall, how satisfied with your life were you 5 years ago?" was found to have a modest to moderate negative correlation ($r = -.261$; $p = .036$). This means that the more respondents' consume tobacco the less likely they were to feel satisfied with their lives 5 years ago. Question B6 "The conditions of my life are excellent" was found to have a moderate negative correlation ($r = -.266$; $p = .032$). This means that the more respondents' consume tobacco the less likely they were to feel that the conditions of their life are excellent. Question B8 "So far I have gotten the important things I want in life" was found to have a moderate negative correlation ($r = -.370$; $p = .002$) with significance of .002. This means that the more respondents' consume tobacco the less likely they were to feel that they have gotten the important things out of life. Question B9 "If I could live my life over, I would change almost nothing" was found to have a modest to moderate negative correlation ($r = -.254$; $p = .041$). This means that the more respondents' consume tobacco the more likely they were to change aspects of their lives if they could live their life over. For the overall life evaluation score, there was a modest to moderate negative correlation ($r = -.281$; $p = .023$). This means that the more respondents' consume tobacco the less likely they were to positively evaluate their own lives.

One significant finding was found between psychotropic medication use and life evaluation. Question B7 “I am satisfied with my life” was found to have a modest to moderate negative correlation ($r = -.241$; $p = .053$). This means that the more respondents’ consume psychotropic medications the less likely they were to be satisfied with their lives.

Table 4. Correlations between Alcohol and Other Drug (AOD) Use and Life Evaluation

(n = 66)	Alcohol	Tobacco	Cannabis	Medications
Which step of the ladder do you stand on?	-.043	.033	-.113	.067
How happy are you?	-.072	-.066	-.117	-.151
How satisfied were you w/ life five years ago?	-.204	-.261*	-.114	-.235
Expected satisfaction w/ life in five years	-.115	-.071	-.189	-.027
Life is close to ideal	-.088	-.207	-.118	-.143
Conditions in life are excellent	-.146	-.266*	.016	-.101
Satisfied with life	-.121	-.229	-.078	-.241*
Attained important things wanted in life	-.150	-.370**	.056	-.219
I would change almost nothing in my life	-.302*	-.254*	.081	-.204
Overall life evaluation	-.207	-.281*	-.067	-.214

*. Correlation is significant at the 0.01 level (2-tailed)
 **. Correlation is significant at the 0.05 level (2-tailed)

Table 5 presents the findings from the affect module and shows the findings on the correlative relationship between respondents' recent positive and negative emotional states and their AOD use. There were no significant findings between any of the four substances measured and affect, meaning that the respondents' recent positive and negative emotional states were not influenced by their AOD use

Table 5. Correlations between Alcohol and Other Drug (AOD) Use and Affect

(n = 66)	Alcohol	Tobacco	Cannabis	Medications
Felt enjoyment yesterday?	.034	.014	-.012	-.054
Felt calm yesterday?	-.103	-.036	.064	-.228
Felt worried yesterday?	-.075	.112	-.079	-.142
Felt sadness yesterday?	-.048	.102	.066	-.123
Felt happy yesterday?	-.067	-.089	-.011	-.046
Felt depressed yesterday?	-.080	.057	.175	-.028
Felt anger yesterday?	-.222	.028	.026	-.169
Felt stress yesterday?	-.054	.070	.018	-.182
Felt tired yesterday?	.050	-.032	.175	-.223
Smile or laugh yesterday?	.137	.123	.095	-.095
Overall affect	-.024	.142	.124	-.173

*. No significant correlations were found

Table 6 presents the findings from the eudaimonic module and shows the findings on the correlative relationship between respondents' mental

flourishing and their AOD use. Pearson r correlations were conducted to interpret this data. There was a significant finding between alcohol use and eudaimonia. Question D2 “I’m always optimistic about my future” was found to have a modest to moderate negative correlation ($r = -.278$; $p = .025$). This means that the more respondents consume alcohol the less likely they were to be optimistic about their future.

There was one significant finding for tobacco use. Question D2 “I’m always optimistic about my future” was found to have a moderate strength negative correlation ($r = -.412$; $p = .001$). This means that the more a respondent consume tobacco the less likely they were to be optimistic about their future.

Psychotropic medication use was found to have one significant finding with the overall Eudaimonic score. It was found to have a modest to moderate negative correlation ($r = -.313$; $p = .030$). This means that the more respondents’ consume psychotropic medication the less likely they were to be flourishing mentally.

Table 6. Correlations between Alcohol and Other Drug (AOD) Use and Eudaimonia

(n = 66)	Alcohol	Tobacco	Cannabis	Medications
Feeling positive	-.206	-.220	.013	-.101
Optimistic about future	-.278*	-.412**	.029	-.191
Free to decide how to live life	-.113	-.093	.078	-.012
What I do is worthwhile	.002	-.123	.003	-.153
Sense of accomplishment	-.147	-.097	-.027	-.052
Resilience	-.087	-.120	.055	-.213
Felt energetic	-.057	-.139	.116	-.088
Felt calm	-.040	-.023	.147	-.082
Felt lonely	.065	.190	-.013	-.209
Overall eudaimonia	-.125	-.212	.147	-.313*

*. Correlation is significant at the 0.05 level (2-tailed)
 **. Correlation is significant at the 0.05 level (2-tailed)

Table 7 shows the findings on the correlative relationship between respondent’s satisfaction of different aspects of life and their AOD use. Pearson r correlations were conducted to interpret this data. There were two significant findings between use of psychotropic medication and domain evaluation/satisfaction. Question E2 “How satisfied are you with your health?” was found to have a modest to moderate negative relationship ($r = -.286$; $p = .021$). This means that the more respondent’s consume psychotropic medications the less likely they were to be satisfied with their health. Question E7 “How satisfied are you with your future security?” was also found to have a

modest to moderate negative relationship ($r = -.255$; $p = .041$). This means that the more respondents' consume psychotropic medications the less likely they were to be satisfied with their future security.

Table 7. Correlations between Alcohol and Other Drug (AOD) Use and

Domain Evaluation

(n = 66)	Alcohol	Tobacco	Cannabis	Medications
Satisfaction w/ standard of living	.072	-.099	-.016	-.215
Satisfaction w/ health	-.014	-.208	-.067	-.286*
Satisfaction w/ life achievements	-.076	-.147	-.029	-.229
Satisfaction w/ relationships	-.124	.027	.095	-.204
Satisfaction w/ feeling safe	-.033	.029	-.091	-.230
Satisfaction w/ sense of community	-.089	.088	.054	.052
Satisfaction w/ future security	-.024	-.026	-.017	-.255*
Satisfaction w/ free time	.119	.062	.091	-.078
Satisfaction w/ local entertainment	-.132	-.162	.028	.009
Satisfaction w/ job or internship	-.038	-.217	-.005	-.056
Overall satisfaction	-.049	-.101	.020	-.223

*. Correlation is significant at the 0.05 level (2-tailed)

CHAPTER FIVE

DISCUSSION

The instrument used by the researchers broke down subjective well-being into five different modules (core evaluation, life evaluation, affect, eudaimonia, and domain evaluation). Each module will be discussed separately since the researchers analyzed each module independently. Significant results from each module will then be discussed.

Core Evaluation

The instrument's first module, the core module, contains five questions that are meant to be a general overview of the four more detailed modules that follow it. There were only very modest to moderate negative correlations between the four substances and the overall general core questions asked of the respondents. These findings reinforce the findings of Pooler (2005) who found that social worker's higher coping skills, and high levels of self-esteem and social support resulted in reduced impairment levels. Deiner et al. (2013) also found no correlation between substance use and life satisfaction.

Life Evaluation

For life evaluation, it was found that alcohol, tobacco and psychotropic medication use had modest negative correlations. The more respondents consume alcohol and tobacco the more likely they were to change aspects of their lives if they could live their life over. Respondents may regret making

certain decisions in their past that may have contributed to increased levels of alcohol and tobacco use, possibly involving the types of relationships they chose to make. Seibert (2001) found that having friends and family members who used substances placed social workers in jeopardy of impairment (impairment implies a diminishment from a previously higher level of functioning). The thought is that personal factors affect professional functioning. Therefore, social workers should focus on making changes to their personal life in order to decrease their alcohol and tobacco use if they feel it could potentially lead to impairment in their professional role. Social workers can be proactive and evaluate different aspects of their personal lives such as friendships and family ties and how they influence their well-being to begin making changes that will improve future life evaluation.

Further, as tobacco use increased, respondents were less likely to feel that the conditions of their lives were excellent, less likely to feel that they have gotten the important things out of life, and less likely to feel satisfied with their lives five years ago. McKennell and Andrew (1980) stated that satisfactions are tied to expectations and standards and are evaluated through present circumstances. Hamama et al. (2013) determined that people evaluate their lives based on factors like expectations, comparisons to others and other cultural aspects using skills such as cognitive evaluation, judgment or declaration. Both highlight expectations and standards as factors in life satisfaction which makes it possible that the social workers surveyed who

reported tobacco use are not satisfied with their current circumstances based on expectations and standards they set for themselves. The reason for the dissatisfaction was not explored in this study, but finding out if tobacco users are more likely to be dissatisfied could prove to be of importance to the social work field. Determining how to improve life conditions and how to find more value in life are two areas that social workers help their clients with. Social workers could be more effective with their help if future research helps determine how to achieve these goals in their own lives.

Increased tobacco use also suggested that social workers were less likely to positively evaluate their own lives overall. Similarly, for psychotropic medication users the more they used the less likely they were to be satisfied with their lives. The reasons for medication use were not established in this study but the majority of medication is used to treat illnesses or conditions that impact a person's overall functioning while tobacco use to relieve stress and anxiety (among other uses) and is recognized to have detrimental effects on health. Medications also cause side effects that can further harm a person's health. Consumers of these substances may want to not use them but continue to do so for different reasons such as necessity or addiction and may contribute to a negative evaluation of life satisfaction.

On the other hand, there is research which indicates that AOD use does not affect a person's subjective well-being negatively. Diener et al. (2013) found that life satisfaction had a modest to moderate correlative

relationship with substance use (AOD use). The modest to moderate negative correlations may suggest that AOD use among the respondents has little influence on how they evaluate their life. Although significant negative correlations exist between life evaluation and AOD use they were modest which may suggest that other factors positively influence and counter the effect that AOD use has on life evaluation. For example, Dougall et al (2001) found that social support is a potent mediator of the relationship between optimism and stress. The more social support a person has the more optimistic they will be and will be better able to deal with their stress. Reduced stress could have a beneficial effect on a person's health and reduce tobacco and medication use; this however is outside of the scope of this study and is an assumption. Although AOD use does not appear to influence life satisfaction as much as other factors such as social support, it is important to note that for the exception a few correlations between AOD use and life evaluation, almost all correlation were negative. This study found that AOD use does influence life satisfaction negatively and that further research into how adaptive coping and other factors counter AOD use should be conducted.

Affect

The questions in the affect module represent a snapshot in time of the person's emotional status the day prior to their participation in the survey (Zajonc, 1980). The respondents were asked how much they had felt particular emotions such as calm, happy, angry, worried or tired. As with the

core module, no significant correlations were found between the various types of substance use and various states of emotion. Because affect may change very quickly due to life circumstances, it may be that the results regarding affect would have been more significant if the respondents had answered on a different, less positive day.

Eudaimonia

Eudaimonia was found to have significant negative correlations with alcohol, tobacco and psychotropic medication use. For alcohol and tobacco, the more it was used the less likely they were to be optimistic about their future. For psychotropic medications it was found that the more respondents consume psychotropic medication the less likely they were to be flourishing mentally. Hamama et al. (2013) stated that the capacity to experience more positive than negative emotion was attributable to a person's ability to flourish. As stated earlier, users are likely to be using the medications to deal with illness or condition and may experience more negative than positive emotion. Tobacco users could also experience more negative emotion due to the addiction. Further, Waterman et al (2008) suggested that identity development will proceed most successfully when individuals are able to identify their best potentials and engage in activities that move toward realizing those potentials. If an individual is able to successfully realize their potentials then it can be said that they are flourishing or experiencing positive levels of eudaimonia. Medication and tobacco users may not consider themselves to be at their best

potential and/or are seeing a decline in their health which moves them further from what they want to be. It is important to determine how medication use influences self-perception; the better a social worker feels about themselves the more effective they can be when working with others.

Fisher and Harrison (2013) report the harm that tobacco and alcohol have on health. For example, alcohol has chronic effects which include permanent loss of memory, cirrhosis of the liver and ulcers. Tobacco, mainly because of nicotine, can lead to heart attacks, seizures and strokes. They are both extremely harmful and can be fatal. This is common knowledge and may help explain why alcohol and tobacco users are less optimistic about their future. Heavy use of these substances is considered to be maladaptive. In contrast, optimists may gain an advantage in dealing with threatening events from their preference for more active coping strategies (Dougall et al, 2001, p 223). This suggests that pessimistic people tend to use more harmful coping methods which can contribute negatively to their eudaimonia or mental flourishing. Again, this is of importance since high levels of alcohol or tobacco use can negatively influence a social worker's ability to help others. Interestingly, cannabis use had the most positive correlations with eudaimonia hinting that cannabis can help people find a positive meaning and purpose in life. However, it is clear that more studies need to be conducted to better determine and understand the relationship between AOD use and eudaimonia.

Wilson (2004) found that the majority of female graduate students in her study did not experience any consequences from their substance use. This was attributed to the increased maturity of being an older student and being held responsible for one's behavior. As only three results were found to be of significance in the eudaimonia module, it suggests that the social workers who took part in the survey were also not experiencing many consequences from their AOD use.

Domain Evaluation

AOD use among social workers had little relationship to how well people thought their lives were going in regards to different aspects of their lives. The survey found that the more medication a respondent used the less likely they were to be satisfied with their health and future security which makes sense given possible health problems and the severity of their health issues. How a person is currently feeling about their health has an impact on what they think their life will be like in the future. Hamama et al. (2013) stated that expectations affect life satisfaction and if a person does not have positive expectations then they may be less satisfied as they evaluate domains in their life. For example, they may not know exactly how long they need to use their medication(s) for or may know that it will be long-term use; this uncertainty may make someone feel poorly about future expectations due to the lack of control they are experiencing.

Chen et al. (2013) found a negative association between general well-being with health control by others. Their findings supported previous findings that perceived self-control in health is associated with fewer acute symptoms, chronic problems, and functional limitations, whereas believing that one's health is in the hands of doctors is associated with more acute symptoms, chronic problems, and functional limitations (Chen et al., 2013, p 1058). It is assumed that the majority of psychotropic medication is prescribed to someone by a doctor. Alcohol, tobacco, and cannabis tend to be used independent of doctor supervision/involvement. This may be why medications were the only substances to have a negative correlation since the respondent's health was in the hands of another person. It may be beneficial to explore how social workers can improve their relationship with psychotropic medication. Increasing a sense of control when it comes to decisions related to health could improve the evaluation of health and future security. Chen et al. (2013) found that well-being was positively related to self-directedness and planning, insight into past, foresight and anticipation while being negatively related to living for today. People who can self-reflect on their past and plan for the future while delaying self-gratification are more likely to feel good about the level of control they have which could possibly increase their sense of future security.

It is interesting to note that though few correlations were significant and those that existed were negative, indicating that as substance use goes up

particular areas of subjective well-being go down, none of the significant correlations found had to do with the use of cannabinoids. All of the negative correlations were limited to alcohol, tobacco and psychotropic medication use.

Limitations

A limitation of the study is that the data was not analyzed by age group. It would have been interesting to compare the answers to various questions among age groups. For example, the NIDA (n.d.) reports that 47.8% of 18-25 year olds and 65.6% of those 26 and older report that they have never used cannabinoids. In contrast, the social work group's composite percentage was 41.9%. It would be interesting to see if when divided by age the percentages more closely match the nationally compiled averages. Similarly, the NIDA data shows that 31.5% of 18-25 year olds have used cannabinoids in the last year and 18.7% in the past month. In the 26 and older group the numbers were 8.6% in the past year and 5.3% in the past month. The composite percentage of the social work group is much lower than the 18-25 year old group at 9.7% using cannabinoids in the last year and 11.3% in the past month, though more closely aligned with the 26 and older group. This could possibly be an effect of social desirability. Social desirability means that a participant may answer questions, even though anonymous, in a way that they think will make them look good to the researcher (Booth-Kewley, Larson & Miyoshi, 2007). Though the survey was anonymous, it may be easier for a participant to admit that they have used a substance in the past, but more difficult to admit current use.

This effect may have caused the current use numbers to be skewed and account for the possible differences from national averages.

Though cannabinoids were chosen as an example because no significant negative correlations were found, it would be instructive to have the age specific data for other categories of substance use as well.

Similarly, specific information regarding responses according to level of education was not collected. Responses regarding life satisfaction might be extremely different between social work students who are just beginning their career and practitioners who have been involved in the field for some time. Those who are new to the profession are enthusiastic and have not yet been worn down by the realities and demands of the job, long term

These two examples lead the researchers to recommend that further collection of data regarding substance use and/or subjective well-being among social workers be compiled with regard to the ages and experience of the respondents, perhaps by using a stratified random sample, so that potential differences between the age groups become clear.

Another limitation included the high level of reliance on chain referral for participation in the study. The researchers assumed that enough individuals would respond to the request for participation and that they would, in turn, refer others to the study.

Further, no data was collected regarding quantity of use. While the data may show that a participant consumes alcohol once per week, no data was collected to see whether that person had one drink or ten.

Recommendations

Future studies should examine other areas which may have an influence on social workers' subjective well-being. Specifically, the respondents should be more thoroughly surveyed about their social support, work environment, specific coping skills and levels of self-esteem in conjunctions with their AOD use. This may give additional useful information about a person's AOD use and SWB.

An additional area for research is to ask respondents directly what their reasons for AOD use are. Though no strong correlations were found between AOD use and SWB correlations in general, there may be correlations found between SWB and the specific reasons for AOD use. People use AODs in many ways, including recreational use, use at social events, habit, use to deal with negative emotions and so on. It may be that the specific type of use has an effect on a person's SWB.

Organizations that employ social workers and universities with social work students can use this information regarding the particular reasons for a person's use to create programs for their employees or students to help them to deal with AOD use that is in reaction to negative feelings or feelings of lack of control.

Summary

Researchers analyzed the results of the data from the five different modules: core evaluation, life evaluation, affect, eudaimonia, and domain evaluation. There were a few modest to moderate negative correlations. These include the area of life evaluation and the use of tobacco or psychotropic drugs, that of eudaimonia and alcohol, tobacco and psychotropic drugs, and within domain and the use of psychotropic medication. No correlations were found in any area with cannabinoid use. Limitations of the study and suggestions for research were then discussed.

APPENDIX A
QUESTIONNAIRE

Core Questions (Box B.1)

The following question asks how satisfied you feel, on a scale from 0 to 10. Zero means you feel “not at all satisfied” and 10 means you feel “completely satisfied.”

A1. Overall, how satisfied are you with life as a whole these days?
{0-10}

The following question asks how worthwhile you feel the things you do in your life are, on a scale from 0 to 10. Zero means you feel the things you do in your life are “not at all worthwhile”, and 10 means “completely worthwhile.”

A2. Overall, to what extent do you feel the things you do in your life are worthwhile?
{0-10}

The following questions ask about how you felt yesterday on a scale from 0 to 10. Zero means you did not experience the feeling “at all” yesterday while 10 means you experienced the feeling “all of the time” yesterday.

A3. How often did you feel happy?
{0-10}

A4. How often did you feel worried?
{0-10}

A5. How often did you feel depressed?
{0-10}

Life Evaluation Questions (Box B.2)

Please imagine a ladder with steps numbered from 0 at the bottom to 10 at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

B1. On which step of the ladder would you say you personally feel you stand at this time?
{0-10}

The following question asks how happy you feel, on a scale from 0-10. Zero means you feel “not at all happy” and 10 means “completely happy.”

B2. Taking all things together, how happy would you say you are?
{0-10}

The following questions ask how satisfied you feel, on a scale from 0-10. Zero means you feel “not at all satisfied” and 10 means “completely satisfied.”

B3. Overall, how satisfied with your life were you 5 years ago?

{0-10}

B4. As your best guess, how satisfied with your life do you expect to feel in 5 years' time?

{0-10}

Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item. Please be open and honest in your responding. The 7 point scale is as follows:

1. Strongly disagree

2. Disagree

3. Slightly disagree

4. Neither agree nor disagree

5. Slightly agree

6. Agree

7. Strongly agree

B5. In most ways my life is close to my ideal.

{1-7}

B6. The conditions of my life are excellent.

{1-7}

B7. I am satisfied with my life.

{1-7}

B8. So far I have gotten the important things I want in life.

{1-7}

B9. If I could live my life over, I would change almost nothing.

{1-7}

Affect Questions (Box B.3)

The following questions ask about how you felt yesterday on a scale from 0-10. Zero means you did not experience the emotion “at all” yesterday while 10 means you experienced the emotion “all of the time” yesterday. Yesterday, how much did you feel:

C1. Enjoyment
{0-10}

C2. Calm
{0-10}

C3. Worried
{0-10}

C4. Sadness
{0-10}

C5. Happy
{0-10}

C6. Depressed
{0-10}

C7. Angry
{0-10}

C8. Stress
{0-10}

C9. Tired
{0-10}

C10. Did you smile or laugh a lot yesterday?
{0-10}

Eudaimonic Questions (Box B.4)

The following are questions about how you feel about yourself and your life. Please use a scale from 0-10 to indicate how you feel. Zero means you “disagree completely” and 10 means “agree completely.”

D1. In general, I feel very positive about myself.

{0-10}

D2. I’m always optimistic about my future.

{0-10}

D3. I am free to decide for myself how to live my life.

{0-10}

D4. I generally feel that what I do in my life is worthwhile.

{0-10}

D5. Most days I get a sense of accomplishment from what I do.

{0-10}

D6. When things go wrong in my life it generally takes me a long time to get back to normal.

{0-10}

The following are ways you might have felt during the past week. Please rate them on a scale from 0-10 , where zero means that you felt that way “not at all” during the past week and 10 means that you felt that way “all of the time.”

D7. Energetic

{0-10}

D8. Calm

{0-10}

D9. Lonely

{0-10}

Domain Evaluation Questions (Box B.5)

The following questions ask how satisfied you feel about specific aspects of your life on a scale from 0-10. Zero means you feel “not at all satisfied” and 10 means “completely satisfied.”

E1. How satisfied are you with your standard of living?
{0-10}

E2. How satisfied are you with your health?
{0-10}

E3. How satisfied are you with what you are achieving in life?
{0-10}

E4. How satisfied are you with your personal relationships?
{0-10}

E5. How satisfied are you with how safe you feel?
{0-10}

E6. How satisfied are you with feeling part of your community?
{0-10}

E7. How satisfied are you with your future security?
{0-10}

E8. How satisfied are you with the amount of time you have to do the things that you like doing?
{0-10}

E9. How satisfied are you with the quality of your local entertainment?
{0-10}

E10. How satisfied are you with your job or internship?
{0-10}

Adapted from OECD. (2013). *OECD guidelines on measuring subjective well-being*. OECD Publishing. <http://dx.doi.org/10.1787/9789264191655-en>

APPENDIX B
ALCOHOL AND OTHER DRUG (AOD) USE QUESTIONNAIRE

AOD use Questionnaire

Have you ever used: (Choose one for each substance)			
1. Alcohol	2. Tobacco	3. Cannabinoids	4. Medications
Never	Never	Never	Never
I used to	I used to	I used to	I used to
1-3 times a year	1-3 times a year	1-3 times a year	1-3 times a year
About once a month	About once a month	About once a month	About once a month
1-3 times a month	1-3 times a month	1-3 times a month	1-3 times a month
Nearly every week	Nearly every week	Nearly every week	Nearly every week
Every week	Every week	Every week	Every week
Once a day	Once a day	Once a day	Once a day

Developed by Gustavo Torres & Katherine Clair Newell Tristán

APPENDIX C
INFORMED CONSENT

INFORMED CONSENT

We would like to ask for your participation in a brief study. The purpose of the study is to examine the relationship between social workers' alcohol or drug use and their subjective well-being. This study is being conducted by Gustavo Torres and Clair Tristán under supervision of Dr. Cory Dennis, California State University, San Bernardino. This study has been approved by the School of Social Work Sub-Committee of the Institutional Review Board, California State University, San Bernardino.

This survey should take approximately 15 minutes or less to complete. If you agree to participate please read this consent form and indicate that you have read it by signing below with an X. Please sign only with an X as your privacy and confidentiality is very important to us. The information provided will remain confidential and will be used only for the purposes of this research project. No information will be provided to any outside persons or agencies.

There are no anticipated risks associated with the completion of this survey. It may be that some questions make you uncomfortable. If so, you are free to discontinue the survey at any time. Though it is unlikely that you will directly benefit from the study, your participation will further the knowledge regarding this subject. For any questions regarding this study or participants' rights please contact: Dr. Cory Dennis at 909-537-3501 or cdennis@csusb.edu Results can be obtained at the California State University, San Bernardino Library after September 2014 and at California State University, San Bernardino annual poster day.

Again, if you agree to participate please sign this consent with only an "X". Next, we ask you to please fill out the survey. After you have finished both the consent form and the survey you will have an opportunity to review your answers and will have a chance to change your answers if needed. The process will then be complete. In participating in the following survey we ask that you answer the questions as honestly as possible. Participation is voluntary; refusal to participate will involve no penalty. You may also discontinue participation at any time without penalty.

APPENDIX D
DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

Thank you for your participation on this research project. The goal of this research is to obtain a better understanding of possible correlations between alcohol or drug use and subjective well-being among Masters of social work practitioners and MSW students. In this study we are interested in examining a person's own feelings of happiness, well-being and life satisfaction while comparing those results with the individual's reported alcohol or drug use. No assumptions are being made about whether that effect will be negative or positive. It is intended that this information will add to the body of knowledge regarding social workers, subjective well-being, and alcohol or drug use.

This study is being conducted by Gustavo Torres and Clair Tristán under the supervision of Dr. Cory Dennis at California State University, San Bernardino. If you have any questions about the study, please feel free to contact Dr. Cory Dennis at 909-537-3501 or cdennis@csusb.edu. If you would like to obtain a copy of the group results of this study, it will be available at the California State University, San Bernardino library after September 2014 as well as being on display at California State University, San Bernardino's annual poster day.

REFERENCES

- Borrello, A. (2005). *Subjective well-being and academic success among college students*. (Order No. 3174525, Capella University). ProQuest Dissertations and Theses, 107-107. Retrieved from <http://search.proquest.com/docview/305361269?accountid=10359>. (305361269).
- Chen, F. F., Jing, Y., Hayes, A., & Lee, J. M. (2013). Two concepts or two approaches? A bifactor analysis of psychological and subjective well-being. *Journal of Happiness Studies*, *14*, 1033-1068.
- Deiner, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist*, *55*(1), 34-43.
- Deiner, E., Inglehart, R., & Tay, L. (2013). Theory and validity of life satisfaction scales. *Social Indicators Research*, *112*, 497-527.
- Dougall, A. L., Hyman, K. B., Hayward, M.C., McFeeley, S., & Baum, A. (2001). Optimism and traumatic stress: The importance of social support and coping. *Journal of Applied Psychology*, *31*(2), 223-245.
- Fisher, G. L., & Harrison, T. C. (2013). *Substance abuse: Information for school counselors, social workers, therapists, and counselors*. New Jersey: Pearson Education, Inc.
- Gaznier, L. (1936). *Reefer madness*. USA: Retrieved from <http://www.imdb.com/title/tt0028346/>
- Getz, L. (2012, November/December). Treating professionals with substance use disorders. *Social Work Today*, *12*(6). Retrieved from <http://www.socialworktoday.com/archive/11312p14.shtml>
- Hall, A. A. (2008). *Knowing the good life: A narrative approach to subjective well-being*. (Order No. 3318016, University of Minnesota). ProQuest Dissertations and Theses, 233. Retrieved from <http://search.proquest.com/docview/304584861?accountid=10359>. (304584861).
- Hamama, L., Ronen, T., Shachar, K., & Rosenbaum, M. (2013). Links between stress, positive and negative affect, and life satisfaction among teachers in special education schools. *Journal of Happiness Studies*, *14*, 731-751.

- Impaired. (2009). *In thefreedictionary.com*. Retrieved October 11, 2013, from <http://www.thefreedictionary.com/impaired>
- Marsiglia, Flavio F., & Becerra, D. (2008). Alcohol and drug problems. In T. Mizrahi, & L. Davis (Eds. in Chief), *Encyclopedia of social work* (20th ed.). Washington, DC, and New York, NY: NASW Press and Oxford University Press.
- McKennell, A. C., & Andrews, M. K. (1980). Models of cognition and affect in perceptions of well-being. *Social Indicators Research*, 8(3), 257-298.
- Moneta, G. B, Vulpe, A., & Rogaten, J. (2012). Can positive affect “undo” negative affect? A longitudinal study of affect in studying. *Personality and Individual Differences*, 53, 448-452.
- National Association of Social Workers. (2003). *Social work speaks*, 6th ed. National Association of Social Workers Policy Statements 2003-2006.
- National Association of Social Workers. (2008). *Code of ethics of the national association of social workers*. Washington, DC. NASW Press.
- National Institute on Alcohol Abuse and Alcoholism. (n.d.). *Drinking statistics*. Retrieved from <http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/drinking-statistics>
- National Institute on Drug Abuse. (n.d.). *Drugs of abuse*. Retrieved from <http://www.drugabuse.gov/drugs-abuse>
- Negreen, S. E. (1995). *A chapter guide on colleague assistance for impaired social workers*. Washington D.C.: National Association of Social Workers.
- Nelson, A. (2012). *A social history of problematic substance use. In Social work with substance users*. New Zealand: Sage Publications.
- OECD. (2013). *OECD guidelines on measuring subjective well-being*. OECD Publishing. <http://dx.doi.org/10.1787/9789264191655-en>
- Pettit, F. A. (2002). A comparison of world-wide web and paper-and-pencil personality questionnaires. *Behavior Research Methods, Instruments, and Computers*, 34(1), 50-54.

- Pooler, D. K. (2005). *The health of social workers in Kentucky: A model of risk and protective factors of professional impairment* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3190033)
- Schaefer, D., & Dillman, D. A. (1998). Development of a standard e-mail methodology: Results of an experiment. *Public Opinion Quarterly*, 62, 378-397.
- Shier, M.L., Graham, J.R. (2011). Mindfulness, subjective well-being, and social work: Insight into their Interconnection from social work practitioners. *Social Work Education*, 30(1), 29-44.
- Siebert, D. C. (2001). *Work and well-being: A survey of distress and impairment among North Carolina social workers* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3007888)
- Tan Bhala, K. W. Y. (2009). *Fortifying virtue ethics: Recognizing the essential roles of eudaimonia and phronesis* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3359515)
- Waterman, A. S., Schwartz, S. J., Conti, R. (2008). The implications of two conceptions of happiness (hedonic enjoyment and eudaimonia) for the understanding of intrinsic motivation. *Journal of Happiness Studies*, 9, 41-79.
- Wilson, N. (2004). *Substance use among female graduate students*. (Order No. 3241186, Virginia Polytechnic Institute and State University). ProQuest Dissertations and Theses. 187-187 p. Retrieved from <http://search.proquest.com/docview/305104813?accountid=10359>. (305104813).
- Yan, W. (2011). *Eudaimonic orientation: The pursuit of the best self* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3515851)

ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:
Team Effort: Gustavo Torres and Clair Tristán
2. Data Entry and Analysis:
Team Effort: Gustavo Torres and Clair Tristán
3. Writing Report and Presentation of Findings:
 - a. Introduction and Literature
Team Effort: Gustavo Torres and Clair Tristán
 - b. Methods
Team Effort: Gustavo Torres and Clair Tristán
 - c. Results
Team Effort: Gustavo Torres and Clair Tristán
 - d. Discussion
Team Effort: Gustavo Torres and Clair Tristán